

ADVANCED DERMATOLOGY ASSOCIATES, LTD.

Patient History

Please Print Clearly

Date: _____

Name _____ Female Male Soc. Sec. # _____

Age _____ Date of Birth ____/____/____
Month Day Year Are you: Single Married Widowed Divorced

Were you referred by a physician? No Yes Name of referring physician _____

Primary care physician's name _____

Patient's Employer _____ Occupation _____

Please state nature, location and duration of skin problem _____

Previous treatments? _____

Are you allergic to any medications? No Yes, specify _____

Do you take Coumadin, aspirin or blood thinners? No Yes, specify _____

Do you require antibiotics prior to surgical/dental procedures? No Yes

List present medications, when started and stopped (including non-prescription and birth control pills):

- 1. _____ 5. _____
- 2. _____ 6. _____
- 3. _____ 7. _____
- 4. _____ 8. _____

YOUR PERSONAL MEDICAL/SURGICAL HISTORY

- Skin cancer/melanoma Diabetes Stomach Disorders
- High blood pressure Cancer/type _____ Hepatitis/Type _____
- Heart attack Kidney disease Positive HIV test
- Heart problem (angina) Stroke/TIA/epilepsy Blood transfusion
- Pacemaker/Defibrillator Artificial joints Thyroid disorders

Any other serious illness? Specify _____

Women

Are you pregnant / nursing now? No Yes

Do you plan to become pregnant in the next year? No Yes

List any surgeries and hospitalizations (with approximate dates):

- 1. _____ 5. _____
- 2. _____ 6. _____
- 3. _____ 7. _____

ENVIRONMENTAL EXPOSURE HISTORY

Which answer best describes your response to 30 minutes of sun in the early summer?

White skin-Unexposed

- Always burns easily; never tans (1)
 Always burns easily; tans minimally (2)
 Burns minimally; tans gradually, light brown (3)

Brown/black skin-Unexposed

- Burns minimally; always tans, brown (4)
 Rarely burns; tans profusely, dark brown (5)
 Never burns; tans profusely, black (6)

Estimate your sun exposure over your lifetime:

- Minimal (avoid sun exposure) Above average (normal outdoor activities with episodic prolonged exposure)
 Average (normal outdoor activities) Excessive (outdoor occupation, actively seek sun exposure)

Have you had any severe sunburns in childhood? No Yes (If yes, approximate number) _____

Do you wear sunscreen daily? No Yes If yes, sunscreen SPF _____

If you anticipate sun exposure which sunscreen SPF do you use? _____

Do you now or have you in the past frequented tanning salons or used tanning beds? No Yes

SOCIAL HISTORY

Do you currently smoke? No Yes (packs/day) _____ Do you drink alcohol? No Yes (drinks/weekly) _____

Have you smoked in the past? No Yes (packs/day) _____ Years _____

Do you have or have you ever had a history of substance abuse? No Yes Type _____

IMMEDIATE FAMILY HISTORY

(Mother, father, brother, sisters, children, grandparents)

- | | | | | |
|--|--|--------------------------------------|---------------------------------------|--|
| <input type="checkbox"/> Skin cancer | <input type="checkbox"/> Asthma | <input type="checkbox"/> Keloids | <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Heart disease |
| <input type="checkbox"/> Melanoma | <input type="checkbox"/> Neurofibromatosis | <input type="checkbox"/> Cystic acne | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Lupus | <input type="checkbox"/> Eczema | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Other _____ |

REVIEW OF SYSTEMS

GENERAL: Generally feel well Weight loss

SKIN: Eczema Psoriasis Keloids

HEART: Pacemaker Artificial heart valve

JOINTS: Arthritis Artificial joint

HEAD: Headaches Dizziness

IMMUNE: Seasonal allergies Asthma

PSYCHIATRIC: Depression Anxiety

MOUTH: Fever blisters/cold sores

GENITALS: Fever blisters Discharge

CHEST: Cough Shortness of breath

PATIENT INFORMATION

Home mailing address: _____

Home phone: _____ Work phone: _____

Emergency contact name and phone number: _____

Pharmacy name, location and phone number: _____

Do you have a prescription plan? No Yes 90 day plan? No Yes

If yes, company _____ Identification # _____